IMPROVING THE DISPUTE RESOLUTION PROCESS IN CALIFORNIA'S MANAGED CARE SYSTEM FINDINGS AND RECOMMENDATIONS

I. STATEMENT OF THE ISSUE

While managed care plans and their providers strive to prevent conflicts, disputes related to coverage, claims, medical necessity and other issues will be an inevitable part of any health care system. An efficient and effective dispute resolution process is essential for public confidence in health care delivery. It is especially important in managed care health plans that use prior authorization as a method for controlling utilization. There is wide perception and concern among consumers, advocates, providers, purchasers, and health plans that some disputes take too long to resolve, current processes are not well understood, disputes are not resolved efficiently, and information that could be gleaned from the process is not consistently used to improve either specific plans or the overall system.

II. ESSENTIAL ELEMENTS

An efficient and effective dispute resolution process must accomplish the following:

- Consumers need to understand their rights and responsibilities; the dispute resolution process and how to navigate it; they must not fear that exercising their rights would result in negative repercussions;
- When problems arise, efforts should be made to resolve them as quickly and as close to the point of service as possible;
- Some consumers will need assistance when they have problems, and assistance should be available, both from inside the health plan and externally;
- Formal processes must be fair; must treat like consumers alike; and must be perceived as fair by all parties in order to maintain support for the system; they must provide adequate opportunity for a full hearing; have consistent decisions; communicate findings to the consumer along with the basis for those findings; utilize qualified decision-makers and reach decisions by applying the facts of the case using explicit standards;
- Formal processes must be efficient for consumers, providers, and plans, with recognition of the severity of the issue;
- Formal processes must provide finality; and
- Any process should both resolve individual issues and systematically provide information for quality improvement and monitoring.

III. CURRENT DISPUTE RESOLUTION PROCESSES

Currently, little data exists relating to consumers' complaints and the severity of those complaints. The DOC is required to publish an annual report that provides data on complaints that come to the DOC through its toll-free hotline. In addition, Knox-Keene plans must report information about complaints pending longer than 30 days. Surveys conducted by several large purchasers provide some insight. One CalPERS-PBGH study found that of the 26% of members with a complaint or problem in 1995, 52% were dissatisfied with the way it was handled by their health plan.

When consumers have a complaint or grievance, a patient's physician is probably the most likely source of help and information for consumers. The formal grievance process available to them varies greatly by sponsor/purchaser (e.g., individual, employer, Medicare, Medi-Cal), health plan (i.e., insurance arrangement, also known as health benefits financial intermediary), health plan product (e.g., HMOs, preferred provider organizations (PPOs), traditional, unmanaged, fee-for-service indemnity (indemnity)), and type and severity of grievance. In general, health plans grievance and appeals processes include two levels of review within the plan. If members are dissatisfied with the result of internal processes, depending on their specific circumstances, many health plans require members to proceed to binding arbitration processes. Several laws require and several accrediting and other organizations recommend certain elements of the dispute resolution process. Besides the formal grievance process in health plans, there may be external grievance structures available to consumers that parallel or supplement these processes.[1]

IV. OBSERVATIONS ON HEALTH PLAN PRACTICES

The dispute resolution process expert resource group examined current grievance processes, albeit not enough to draw firm conclusions, and found: lack of consistency, ineffective communication, variable reporting, and some positive examples of use of complaint data for quality improvement.

V. RECOMMENDATIONS

The line between utilization review and grievance processes is not a clear one. From a consumer's perspective, whenever a plan denies a patient or his or her physician's request, he or she enters the grievance process (i.e., this is the point at which the patient receives information about the basis upon which a decision is made). This paper addresses issues related to the grievance process from the consumer's perspective, including some aspects concerning utilization review.

A. Collaborative Development and Non-Duplication of Effort

1. Any of the recommendations below would benefit from a collaborative process in which health plans, purchasers, providers, consumer advocates and other stakeholders form a working group to develop the detailed terms of the proposal. In addition, many recommendations reflect existing law applied to specific populations (e.g., Medicare or Medicaid), to those health plans regulated by Knox-Keene, or standards privately developed (e.g., by accreditation bodies). Where requirements already exist, we recommend building on existing standards rather than creating completely new ones. Similarly, recommendations are intended to recognize and build on existing community resources.

B. Broad Application

[1] For example, enrollees in Knox-Keene regulated plans may file a complaint with the DOC prior to binding arbitration or after binding arbitration, Health and Safety Code Section 1368(b)1B.

2. In those situations where ERISA preemptions restrict the regulation and oversight of health plan processes, voluntary adoption and implementation of the recommendations by purchasers, employers, and plan administrators is strongly encouraged by the Task Force.

C. Consistency and Common Standards for Internal Plan Grievance and Appeals Processes

Individual consumers move among health plans and types of plans. Employers may change coverage; consumers may move in and out of Medi-Cal, change jobs, get Medicare coverage, or select different individual coverage. Because of this fluidity, and because an essential element is to treat like consumers alike, enrollees in all types of plans (HMOs, PPOs, POS, and indemnity) should have equivalent or consistent procedural rights and protections, regardless of type or purchaser. While there may be greater perceived need for grievance processes in health plans with more selective networks and greater restrictions, consistency among dispute resolution processes would help all consumers. A consistent process would require consumers to learn only one basic system, and it would provide for better information, quality improvement, and choice. This would enable consumers to advocate more effectively for themselves, potentially improving satisfaction with results.

3. The Task Force recommends that the legislature develop and adopt, to the extent it has power to do so, consistent standards regarding dispute resolution processes for all health plans. Those standards should include (where they are not already required):

(a) Timing requirements. (1) Turn-around time for handling complaints at all levels of the dispute resolution process, with time adjusted for severity of problem. Specifically, responses to non-urgent complaints should be provided within 30 days, except under special circumstances. Responses to urgent complaints, defined as a situation in which the standard time frame could jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function as determined by a physician, should be provided within 72 hours as required by the Health Care Financing Administration.[2] (2) There should also be minimum standard "periods of limitation" within which consumers must submit a grievance or appeal. In general, this period should be at least one year. However plans should encourage consumers to apply sooner through full notification of the grievance process. In addition, good cause exceptions provisions should be allowed (e.g., in the case of a patient who later learns of a previously available treatment option that was not offered as an alternative).

(b) Terminology and data collection. The State should develop, in collaboration with stakeholders, standard definitions for the meaning of terms commonly used in

[2] The Knox-Keene Act also already contains time frames for handling complaints, including expedited problems, though the 72-hour window is not a legislated time frame.

grievance processes; categories for reporting complaint types; and minimum standards for how data on types of complaints is collected.[3]

(c) Communication of processes. There should be consistency of how and when health plans inform consumers of how to use dispute resolution processes before and upon "grievable incidents". In addition, all plans should provide examples of well-prepared appeals upon request and make practice guidelines for frequent conditions available for consumers to review.[4]

(d) Full and complete explanations by health plans of their grievance or appeals decisions.[5] If an in-plan physician's recommendation is denied by an organization (whether medical group or health plan), both the physician and patient should receive written notice of the decision that was made, the reasons for the denial, the specific health plan contractual provision on which the decision is based, if applicable, the information that was reviewed in making the decision, any expert opinions relied upon, information and instructions on how to appeal the decision, timing, and the types of additional information that potentially would alter the decision in the next review.

(e) Public reports. Plans should provide to the state for public record and make available to consumers upon request annual reports aggregating the number, type, and disposition of issues raised by condition or type of complaint, and sorted by medical group for groups over some size threshold (e.g., percent of enrollees or number of doctors). They should also provide a summary of the reasons decisions were upheld or overturned, including the basis upon which decisions are reached for particular types of complaints.[6] They should include a description of the process by which complaints were handled, analysis of those complaints, and how the plan used the information from those complaints for quality improvement. The plan's board of directors should receive more detailed reports. (This would supplement current Knox-Keene requirements whereby plans must report complaints pending longer than 30 days, track their resolution, analyze the complaints, and use the information for quality improvement.)

(f) Requirements and procedures for access to external resources for assistance. There should be standard requirements for access to formal review outside of the health

[3] DOC has already developed common complaint categories for its hotline for the classification of types of complaints.
[4] The Knox-Keene Act currently requires the disclosure of the grievance system and the DOC hotline.
[5] When a Knox-Keene regulated health plan denies coverage for treatment, the plan must give the patient and provider the specific clinical criteria, if any, that was used in the denial (Section 1363.5).
[6] The task force considered requiring plans to establish case-by-case precedents. While the task force believes that establishing consistency and making public the basis of health plan decisions, we think that requiring case-by-case precedents have limited applicability, could be overly burdensome on health plans, and potentially limit plans' discretion to resolve issues quickly and efficiently through compromise as close to the point of service as possible.

plans for assistance and specific procedures for how and when consumers have access.

(g) Medical group grievance and appeals processes if a medical group is delegated responsibility and authority to act on behalf of a health plan (e.g., timing requirements would include complaint processing time at the medical group level).

(h) Clear government oversight. Those agencies at the state and federal level with regulatory authority over health plans should coordinate activities to ensure consistent standards. In addition, the agencies should provide a single "800" number that refers consumers to the appropriate agency.

The development of these standards should include consultation with health plans, medical groups, consumers, consumer advocates, regulators, and other stakeholders. The goal of these deliberations should be to establish mandatory complaint processes that encourage resolution as close to the point of service as possible, to structure balanced and efficient processes, and to elicit reporting that is comparable and equitable.

D. Consumer Empowerment

4. To be educated and empowered, consumers in all types of plans need full information on their rights and how to exercise them. Information should include a "bill of rights and responsibilities" received on enrollment, describing the complaint processes (as is required under current law for Knox-Keene plans). Also, when a denial or "grievable incident" occurs, appropriate information should be provided to the patient. In order to maintain a non-legalistic doctor-patient relationship and to prevent a massive paper flow, the legislature should review current law to ensure the following standards exist for all consumers:

(a) There should be notice of next steps at every stage where a member expresses disagreement with a provider or plan decision as well as adequate explanation of the patient's rights and the basis of the decision.[7]

(b) If a patient disagrees with his or her doctor, the patient should be given at least oral notice (not necessarily in writing) of the availability of and access to a second opinion and the grievance process. However, when the decision of the medical group or plan differs from that of the patient's physician, the notice should be in writing. *Plans should be required to pay for second opinions within the consumer's health plan.*

E. Consumer Assistance Through Plans

5. While the goal of the dispute resolution process should be to educate and empower consumers to be their own advocates, some consumers need assistance exercising their rights. Physicians should serve as their patient's advocate. In addition, plans

[7] The Knox-Keene Act requires such notices at every stage.

must have adequate internal systems and information to provide assistance. The Task Force recommends that private accreditation and quality audit standards where applicable should require plans to demonstrate support to consumers seeking to appeal, including coaching, adequate explanation of denial, and access to supporting documentation.

6. In addition, the Task Force encourages health plans to examine and adopt best practices as this will enhance member retention. Some exemplary efforts include:

(a) seeking the opinion of outside specialists in the relevant medical specialty for issues related to medical necessity or experimental and investigational treatments; and

(b) allowing members to attend reviews by teleconference if the member can not or is not welcome to attend in person.

F. External Consumer Assistance

Because even the best health plan's internal processes will not be perfect, some consumers will also need an independent external resource to go to for information and assistance. In addition, some consumers fear retribution from their provider or plan and are reluctant to pursue assistance from their employers.

7. The Task Force recommends that the State ensure all consumers access to some form of independent external assistance or external ombudsman programs. While this resource should be available to consumers at any time, there must be education on how to use the service as well as reasonable limitations on funding of the services to prevent overuse. Currently, external resources exist, but access to these resources varies greatly based on the individual consumer's circumstances. Appropriate activities performed by external resources include: developing and distributing educational material, providing referrals to existing resources, brief counseling and advising on problem resolution. Specific recommendations would benefit particularly from being designed through a collaborative process that includes stakeholders because they should be based on a review of existing resources and an assessment of how to use them most effectively. The State should require publicly-supported external information resources, as part of the request for proposal process, and encourage other private information resources to compile and publicly share data regarding complaints to identify systemic problems.

According to Task Force members that participated in the anonymous delphi questionnaire, the most appropriate source of funding for such a function is from a premium tax or other mechanism that applies to all covered lives.

G. Independent Third Party Review

8. All consumers should have the right to an independent third-party review available for all enrollees for grievances related to issues of experimental treatments[8] and medical necessity/appropriateness (when a patient request is supported by a provider in the consumer's health plan). The third-party should determine whether the treatment or service under consideration is clearly appropriate or clearly inappropriate. Where evidence is equivocal or mixed, the third-party should make a determination on the basis of a preponderance of evidence of effectiveness. The current right to file complaints with the DOC should be limited to those grievances for which independent review is not available, such as coverage, courtesy, or quality of service disputes.

9. To ensure the third-party reviewers are insulated from inappropriate political pressures and conflict of interest and to prevent undue influence, this function should not be performed by the regulatory oversight agency. Rather, an independent (i.e., free from conflict of interest, such as relationships to health plans), non-political entity should be used. The qualifications of the decision-makers must include relevant medical and contract interpretation expertise. The entity(ies) that conducts the reviews should be certified by an appropriate state agency. To be certified, entities should be required to demonstrate a capacity to make appropriate judgments, and such certification should be periodically reviewed, based on accumulated experience. The appropriate state agency or its delegee should serve as the coordinator of such reviews (e.g., assigning cases to specific entities and initial screening to see if the patient meets threshold requirements).

10. Third-party review should be accessible only after internal plan processes have been completely exhausted (i.e., consumers have complied with necessary steps in the internal process, even if the plan has not completed its process), with expedited processes for emergency situations. Additional measures should be considered to ensure that the expense of independent third-party review does not significantly raise the cost of premiums (e.g., financial or "merit" thresholds or nominal fees).

11. For decisions that relate to medical necessity, the cost of which is not more than some threshold amount (e.g., $50-$200,000), an appropriately qualified individual could make the determination. If the treatment in controversy costs more than the threshold, the third-party review should be conducted by a qualified three-person panel.[9]

H. Arbitration Standards

While arbitration is an important aspect of the dispute resolution process, the Dispute Resolution expert resource group did not develop any recommendations in this area.

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[8] All Knox-Keene regulated health plans are required by AB 1663 to use an external review process for experimental treatments. California was a leader with this legislation.

[9] This recommendation mirrors AB 1663, under which experimental treatments over a threshold must be reviewed by a panel of three, and experimental treatments under the threshold may be reviewed by an individual.

I. Assessment

12. Health plans, providers, foundations, consumer groups, etc., should be encouraged to assess the efficacy of the full range of dispute resolution mechanisms–non-binding arbitration, mediation, neutral fact-finders. The use of such mechanisms should be linked to publicly disseminated independent evaluation of how well they meet the principles set forth in the list of "Essential Elements" above.

VI. ADDITIONAL ISSUE FOR DISCUSSION: ERISA (See background paper)

IMPROVING THE DISPUTE RESOLUTION PROCESS IN CALIFORNIA'S MANAGED CARE SYSTEM BACKGROUND PAPER

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- Formal processes must be efficient for consumers, providers, and plans, with recognition of the severity of the issue;
- Formal processes must provide finality; and
- Any process should both resolve individual issues and systematically provide information for quality improvement and monitoring.

III. CURRENT DISPUTE RESOLUTION PROCESSES

The dispute resolution group reviewed literature on a wide range of dispute resolution processes, existing systems, and proposed models.

A. Consumers' Experiences

Currently, little data exists relating to consumers' complaints and experience of problems with their health plans. In particular, current data sources give little information about the severity of the problem. According to Section 1397.5 of the Health and Safety Code, the DOC is required to publish an annual report that provides

data on complaints that come to the DOC through its toll-free hotline. In addition, Knox-Keene plans must report information about complaints pending longer than 30 days. Surveys conducted by several large purchasers provide some insight.

In the Health Plan Value Check survey conducted by the California Public Employees Retirement System (CalPERS) and the Pacific Business Group on Health (PBGH),[10] they found that in 1995 26% of PBGH members surveyed reported having a complaint or problem with their health plan. The percentage was slightly lower for health maintenance organization (HMO) and indemnity plan members and higher for point-of-service plan (POS) members.

Of those who complained, 30% were satisfied or very satisfied with the way their health plan handled their most recent problem, while 52% were dissatisfied or very dissatisfied. The rate of satisfaction varied among health plans, from 19% to 47% satisfied with the way in which problems were handled. Dissatisfaction may be due to many reasons. However, the survey found that 63% of those who complained said "I had to explain the problem over and over", and 42% said "I was given incorrect information". On the other hand, the survey also found that 47% said "Someone at my health plan took responsibility for resolving the problem".

According to the Health Plan Value Check survey, 12% of disputes were resolved on a same-day basis, another 14% were resolved within 10 days. Twenty-six percent of complaints took more than 30 days to resolve; 35% of complaints were still pending as of the date of the survey.

In 1995, CalPERS conducted an exit survey of individuals switching health plans during the open enrollment period.[11] Typically, less than 5% of enrollees voluntarily change plan at open enrollment. They found that almost half of those who changed plans had some difficulty with the dispute resolution process. Among reasons for changing plans, 33.4% of members said claims issues were not resolved to their satisfaction, and 14.8% said appeals were not resolved to their satisfaction. Slightly more than a quarter said that their problem with the dispute process was the most important reason for changing plans. Seventeen percent said that claims not resolved was their overriding reason for changing plans, 5.4% said that appeals not resolved and 4.2% said that disappointment with their plan's appeals process was their overriding reason. Furthermore, plan-specific scores on these measures varied significantly.

B. Current Health Plan Practices

When consumers have a complaint or grievance, a patient's is probably the most likely source of help and information for consumers. The formal grievance process available to them varies greatly by sponsor/purchaser (e.g., individual, employer, Medicare, Medi-Cal), health plan (i.e., insurance arrangement, also known as health benefits financial

[10] "Health Plan Value Check: A Survey of Health Plan Satisfaction, Value, and Quality", sponsored by the California Public Employee's Retirement System and the Pacific Business Group on Health, 1995.
[11] "1995 Open Enrollment Exit Survey", California Employee's Retirement System, April 16, 1996.

intermediary), health plan product (e.g., HMOs, preferred provider organizations (PPOs), traditional, unmanaged, fee-for-service indemnity (indemnity)), and type and severity of grievance. In general, health plans' grievance and appeals processes include two levels of review within the plan. If members are dissatisfied with the result of internal processes, depending on their specific circumstances, many health plans require members to proceed to binding arbitration processes.

Several laws require and several accrediting and other organizations recommend certain elements of the dispute resolution process.[12] For Knox-Keene regulated health plans, in 1995, SB 689 (Rosenthal), comprehensively reformed existing law pertaining to plan grievance processes, requiring health plans to resolve grievances within 30 days "whenever possible", to create an expedited review process for grievances pertaining to life-threatening conditions, to inform their members in every correspondence pertaining to a grievance and through plan documents of their ability to submit grievances to the Department of Corporations (DOC), and to track and report to the Department those grievances that remain pending unresolved for more than 30 days. In addition, SB 689 directed the DOC to create a toll-free telephone hotline through which enrollees could submit their complaints, before or after arbitration, to the DOC, on an expedited basis if warranted. Section 1397.5 requires the DOC to report data on the hotline complaints. Some health plans feel that it may not be appropriate for Knox-Keene to hear consumer complaints because, under political pressure, DOC may favor consumers, ordering health plans to pay even when they are not contractually obligated; plans comply because DOC has so much power over them. Some consumer groups, on the other hand, would argue that the DOC favors the health plans.

Current law also establishes standards regarding arbitration for Knox-Keene regulated health plans including: AB 3260 (Bornstein) which requires Knox-Keene regulated health plans that require arbitration to inform new health plan members that enrolling with the plan waives their right to jury trial; SB 1660 (Rosenthal) which provides that cases involving less than $200,000 would involve a single neutral arbitrator, requires plans to have expeditious processes in place by which arbitrators were selected, and requires plans to have provisions for hardship waivers. In addition, the State Supreme Court established, in Engalla v. Kaiser, that an individual may withdraw from the arbitration and pursue court action if the individual can demonstrate that the process was tainted by fraud, material misrepresentation or misfeasance in the performance of the

[12] For HMOs and other Knox-Keene regulated health plans, Knox-Keene Health Care Service Plan Act of 1975, including amendments enacted in 1996, Section 1368 and Barclays California Code of Regulation, Section 1300.68 and Health and Safety Code, Section 1368-1368.1; For PPOs and FFS plans, Insurance Code Section 510, 12921.1, 12921.3, 12921.4; For Medicaid plans, Welfare and Institutions Code, Sections 10950, 14450 and Regulations, Title 22, Section 5104.1, 53858, 53893, 53914; For Medicare plans, Federal Register, HCFA Regulations 42CFR Part 417. Other standards include, Federal HMO Qualification Requirements, Health Plan Requirements Guide, June 1994; Health Carrier Grievance Procedure Model Act, National Association of Insurance Commissioners, 1996; 1997 Data Collection Tools and 1997 surveyor Guidelines, National Committee on Quality Assurance; Joint Commission on Accreditation of Hospital Organizations; and IPA Association of America: Complaint, Grievance and Appeal Procedure, 1995.

arbitration agreement. Arbitration, however, is rarely used except by health plans that indemnify their physicians against medical malpractice. Most grievances that seek a reversal of a plan decision can be handled through the plan of DOC process. When medical malpractice has occurred, the only resort is arbitration or lawsuit because usually the only remedy is monetary compensation.

While these provisions apply to Knox-Keene regulated health plans, they do not apply to Department of Insurance (DOI) regulated plans. However, members of plans marketed by DOI regulated-insurers may also call a toll-free number. The Knox-Keene provisions also do not apply to coverage provided by self-insured employers which is exempted by the Employee Retirement Income Security Act of 1974 (ERISA). In addition, if an ERISA plan loses a court case, damages are limited to recovery of costs and may not include punitive or compensatory damages.

Besides the formal grievance process in health plans, there may be external grievance structures available to consumers that parallel or supplement these processes. Examples include processes through employers and employee benefits departments (though rarely available through smaller employers), and, for Medicare or Medi-Cal beneficiaries, formal rights to an independent hearing and access to judicial review. Furthermore, Medicare beneficiaries have available to them Health Insurance Counseling and Advocacy Programs (HICAPs) which assist them with filing appeals and exercising their rights.

Consumers may also get assistance from their agents/brokers, consumer advocates, and attorneys. We currently lack sufficient evidence to know how widespread is the availability of these ancillary processes and whether particular processes or types of assistance are working well or consistently. The most costly and least efficient method of resolution is through the courts. This alternative, however, is not available to those who have submitted to binding arbitration.

IV. OBSERVATIONS ON HEALTH PLAN PRACTICES

The observations below stem from an informal review of internal plan materials (including their Evidence of Coverage, descriptions of grievance processes on file with the applicable regulatory authority, sample correspondence with grievants, etc.) as well as responses to specific survey questions submitted to the ERG by several HMOs and PPOs in California describing their dispute resolution processes. The ERG survey generated insufficient responses to draw firm conclusions, and we recognize that internal documents may not be completely consistent with actual practice.

A. Lack of Consistency

There are many differences among plans and across the industry in their processes, timing, definitions and categorization of complaints, grievances, and appeals. Examples include: (1) the “statute of limitations” for filing appeals and grievances range from 60 days to unlimited; (2) health plans use different terms to describe the same or very similar processes (e.g., inquiry, concern, complaint, grievance, and appeal are used inconsistently); (3) health plans use different descriptions for the reasons members

complain; and (4) some health plans allow consumers to appear in person at all stages of review, others allow consumers to appear only at one stage or set up special processes; and (5) health plans differ in the extent to which they allow consumers to have someone assist or represent them at a plan's review.

B. Ineffective Communication

Letters from plans to consumers explaining denials do not consistently include sufficiently detailed explanations to enable an individual to judge the basis of the decision or to determine whether further action would be worthwhile. Some plans do not provide specific information to consumers about what materials were reviewed in making the decision, so the consumer can not determine whether a thorough review occurred.

C. Variable Reporting

Certain plans may not track or were unable to provide on request a summary of the disposition of complaints. Some plans use a category of "inquiry" or similar term for an initial complaint which if resolved satisfactorily is not recorded or tracked for summary level reporting.

D. Use of Complaint Data for Quality Improvement

In general, health plans that are HMOs have specified procedures to use grievance data for quality improvement in accordance with Knox-Keene requirements. Some plans effectively use grievance data for quality improvement and internal monitoring of dispute resolution processes. For example, grievance data has been used to clarify the description of the grievance process in the Evidence of Coverage and Member Handbook and to modify and update medical treatment policies to reflect current practice.

V. RECOMMENDATIONS

The line between utilization review and grievance processes is not a clear one. From a consumer's perspective, whenever a plan denies a patient or his or her physician's request, he or she enters the grievance process (i.e., this is the point at which the patient receives information about the basis upon which a decision is made). This paper addresses issues related to the grievance process from the consumer's perspective, including some aspects concerning utilization review.

A. Collaborative Development and Non-Duplication of Effort

1. Any of the recommendations below would benefit from a collaborative process in which health plans, purchasers, providers, consumer advocates and other stakeholders form a working group to develop the detailed terms of the proposal. In addition, many recommendations reflect existing law applied to specific populations (e.g., Medicare or Medicaid), to those health plans regulated by Knox-Keene, or standards privately developed (e.g., by accreditation bodies). Where requirements already exist, we recommend building on existing standards rather than creating completely new ones. Similarly, recommendations are intended to recognize and build on existing community resources.

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2. In those situations where ERISA preemptions restrict the regulation and oversight of health plan processes, voluntary adoption and implementation of the recommendations by purchasers, employers, and plan administrators is strongly encouraged by the Task Force.

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3. The Task Force recommends that the legislature develop and adopt, to the extent it has power to do so, consistent standards regarding dispute resolution processes for all health plans. Those standards should include (where they are not already required):

(a) Timing requirements. (1) Turn-around time for handling complaints at all levels of the dispute resolution process, with time adjusted for severity of problem. Specifically, responses to non-urgent complaints should be provided within 30 days, except under special circumstances. Responses to urgent complaints, defined as a situation in which the standard time frame could jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function as determined by a physician, should be provided within 72 hours as required by the Health Care Financing Administration.[13] (2) There should also be minimum standard "periods of limitation" within which consumers must submit a grievance or appeal. In general, this period should be at least one year. However plans should encourage consumers to apply sooner through full notification of the grievance process. In addition, good cause exceptions provisions should be allowed (e.g., in the case of a patient who later learns of a previously available treatment option that was not offered as an alternative).

[13] The Knox-Keene Act also already contains time frames for handling complaints, including expedited problems, though the 72-hour window is not a legislated time frame.

(b) Terminology and data collection. The State should develop, in collaboration with stakeholders, standard definitions for the meaning of terms commonly used in grievance processes; categories for reporting complaint types; and minimum standards for how data on types of complaints is collected.[14]

(c) Communication of processes. There should be consistency of how and when health plans inform consumers of how to use dispute resolution processes before and upon "grievable incidents". In addition, all plans should provide examples of well-prepared appeals upon request and make practice guidelines for frequent conditions available for consumers to review.[15]

(d) Full and complete explanations by health plans of their grievance or appeals decisions.[16] If an in-plan physician's recommendation is denied by an organization (whether medical group or health plan), both the physician and patient should receive written notice of the decision that was made, the reasons for the denial, the specific health plan contractual provision on which the decision is based, if applicable, the information that was reviewed in making the decision, any expert opinions relied upon, information and instructions on how to appeal the decision, timing, and the types of additional information that potentially would alter the decision in the next review.

(e) Public reports. Plans should provide to the state for public record and make available to consumers upon request annual reports aggregating the number, type, and disposition of issues raised by condition or type of complaint, and sorted by medical group for groups over some size threshold (e.g., percent of enrollees or number of doctors). They should also provide a summary of the reasons decisions were upheld or overturned, including the basis upon which decisions are reached for particular types of complaints.[17] They should include a description of the process by which complaints were handled, analysis of those complaints, and how the plan used the information from those complaints for quality improvement. The plan's board of directors should receive more detailed reports. (This would supplement current Knox-Keene requirements whereby plans must report complaints pending longer than 30 days, track their resolution, analyze the complaints, and use the information for quality improvement.)

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[15] The Knox-Keene Act currently requires the disclosure of the grievance system and the DOC hotline.

[16] When a Knox-Keene regulated health plan denies coverage for treatment, the plan must give the patient and provider the specific clinical criteria, if any, that was used in the denial (Section 1363.5).

[17] The task force considered requiring plans to establish case-by-case precedents. While the task force believes that establishing consistency and making public the basis of health plan decisions, we think that requiring case-by-case precedents have limited applicability, could be overly burdensome on health plans, and potentially limit plans' discretion to resolve issues quickly and efficiently through compromise as close to the point of service as possible.

(f) Requirements and procedures for access to external resources for assistance. There should be standard requirements for access to formal review outside of the health plans for assistance and specific procedures for how and when consumers have access.

(g) Medical group grievance and appeals processes if a medical group is delegated responsibility and authority to act on behalf of a health plan (e.g., timing requirements would include complaint processing time at the medical group level).

(h) Clear government oversight. Those agencies at the state and federal level with regulatory authority over health plans should coordinate activities to ensure consistent standards. In addition, the agencies should provide a single "800" number that refers consumers to the appropriate agency.

The development of these standards should include consultation with health plans, medical groups, consumers, consumer advocates, regulators, and other stakeholders. The goal of these deliberations should be to establish mandatory complaint processes that encourage resolution as close to the point of service as possible, to structure balanced and efficient processes, and to elicit reporting that is comparable and equitable.

D. Consumer Empowerment

4. To be educated and empowered, consumers in all types of plans need full information on their rights and how to exercise them. Information should include a "bill of rights and responsibilities" received on enrollment, describing the complaint processes (as is required under current law for Knox-Keene plans). Also, when a denial or "grievable incident" occurs, appropriate information should be provided to the patient. In order to maintain a non-legalistic doctor-patient relationship and to prevent a massive paper flow, the legislature should review current law to ensure the following standards exist for all consumers:

(a) There should be notice of next steps at every stage where a member expresses disagreement with a provider or plan decision as well as adequate explanation of the patient's rights and the basis of the decision.[18]

(b) If a patient disagrees with his or her doctor, the patient should be given at least oral notice (not necessarily in writing) of the availability of and access to a second opinion and the grievance process. However, when the decision of the medical group or plan differs from that of the patient's physician, the notice should be in writing. *Plans should be required to pay for second opinions within the consumer's health plan.*

E. Consumer Assistance Through Plans

[18] The Knox-Keene Act requires such notices at every stage.

5. While the goal of the dispute resolution process should be to educate and empower consumers to be their own advocates, some consumers need assistance exercising their rights. Physicians should serve as their patient's advocate. In addition, plans must have adequate internal systems and information to provide assistance. The Task Force recommends that private accreditation and quality audit standards where applicable should require plans to demonstrate support to consumers seeking to appeal, including coaching, adequate explanation of denial, and access to supporting documentation.

6. In addition, the Task Force encourages health plans to examine and adopt best practices as this will enhance member retention. Some exemplary efforts include:

(a) seeking the opinion of outside specialists in the relevant medical specialty for issues related to medical necessity or experimental and investigational treatments; and

(b) allowing members to attend reviews by teleconference if the member can not or is not welcome to attend in person.

F. External Consumer Assistance

Because even the best health plan's internal processes will not be perfect, some consumers will also need an independent external resource to go to for information and assistance. In addition, some consumers fear retribution from their provider or plan and are reluctant to pursue assistance from their employers.

7. The Task Force recommends that the State ensure all consumers access to some form of independent external assistance or external ombudsman programs. While this resource should be available to consumers at any time, there must be education on how to use the service as well as reasonable limitations on funding of the services to prevent overuse. Currently, external resources exist, but access to these resources varies greatly based on the individual consumer's circumstances. Appropriate activities performed by external resources include: developing and distributing educational material, providing referrals to existing resources, brief counseling and advising on problem resolution. Specific recommendations would benefit particularly from being designed through a collaborative process that includes stakeholders because they should be based on a review of existing resources and an assessment of how to use them most effectively. The State should require publicly-supported external information resources, as part of the request for proposal process, and encourage other private information resources to compile and publicly share data regarding complaints to identify systemic problems.

According to Task Force members that participated in the anonymous delphi questionnaire, the most appropriate source of funding for such a function is from a premium tax or other mechanism that applies to all covered lives.

G. Independent Third Party Review

8. All consumers should have the right to an independent third-party review available for all enrollees for grievances related to issues of experimental treatments[19] and medical necessity/appropriateness (when a patient request is supported by a provider in the consumer's health plan). The third-party should determine whether the treatment or service under consideration is clearly appropriate or clearly inappropriate. Where evidence is equivocal or mixed, the third-party should make a determination on the basis of a preponderance of evidence of effectiveness. The current right to file complaints with the DOC should be limited to those grievances for which independent review is not available, such as coverage, courtesy, or quality of service disputes.

9. To ensure the third-party reviewers are insulated from inappropriate political pressures and conflict of interest and to prevent undue influence, this function should not be performed by the regulatory oversight agency. Rather, an independent (i.e., free from conflict of interest, such as relationships to health plans), non-political entity should be used. The qualifications of the decision-makers must include relevant medical and contract interpretation expertise. The entity(ies) that conducts the reviews should be certified by an appropriate state agency. To be certified, entities should be required to demonstrate a capacity to make appropriate judgments, and such certification should be periodically reviewed, based on accumulated experience. The appropriate state agency or its delegee should serve as the coordinator of such reviews (e.g., assigning cases to specific entities and initial screening to see if the patient meets threshold requirements).

10. Third-party review should be accessible only after internal plan processes have been completely exhausted (i.e., consumers have complied with necessary steps in the internal process, even if the plan has not completed its process), with expedited processes for emergency situations. Additional measures should be considered to ensure that the expense of independent third-party review does not significantly raise the cost of premiums (e.g., financial or "merit" thresholds or nominal fees).

11. For decisions that relate to medical necessity, the cost of which is not more than some threshold amount (e.g., $50-$200,000), an appropriately qualified individual could make the determination. If the treatment in controversy costs more than the threshold, the third-party review should be conducted by a qualified three-person panel.[20]

H. Arbitration Standards

While arbitration is an important aspect of the dispute resolution process, the Dispute Resolution expert resource group did not develop any recommendations in this area.

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[19] All Knox-Keene regulated health plans are required by AB 1663 to use an external review process for experimental treatments. California was a leader with this legislation.

[20] This recommendation mirrors AB 1663, under which experimental treatments over a threshold must be reviewed by a panel of three, and experimental treatments under the threshold may be reviewed by an individual.

I. Assessment

12. Health plans, providers, foundations, consumer groups, etc., should be encouraged to assess the efficacy of the full range of dispute resolution mechanisms–non-binding arbitration, mediation, neutral fact-finders. The use of such mechanisms should be linked to publicly disseminated independent evaluation of how well they meet the principles set forth in the list of "Essential Elements" above.

VI. ADDITIONAL ISSUE FOR DISCUSSION: ERISA

The Task Force has not had an opportunity to discuss how to address the desire for consistency and common standards given the important role played by ERISA. Without voluntary employer or federal action, this is not possible with respect to health coverage for the significant portion of Californians who have employer-sponsored health benefit plans because ERISA establishes the standards governing such self-insured plans. For employer-sponsored plans, federal law governs both the procedural rights available to consumers (e.g., levels of appeal, timing, notice requirements) and the substantive remedies (e.g., bar on compensatory, pain/suffering or punitive damages). While ERISA provides the benefit to employers of consistency across state lines, it significantly undercuts efforts to create consistency within California.

Options include: (a) make no reference to ERISA, (b) recommend employers voluntarily include Task Force dispute resolution standards in contract obligations for health plans, (c) recommend the Department of Labor use the Task Force dispute resolution standards to revise ERISA standards (the DOL is soliciting comments between now and 11/7/97 on proposed revisions), (d) recommend Congress amend ERISA to provide more consistent procedural rights, (e) recommend Congress amend ERISA to provide the same substantive rights available under state law, and (f) recommend Congress amend ERISA to allow actions directly against health plans (not employers), with or without amending scope of substantive remedies.